APPENDIX 10

PRIOR AUTHORIZATION AODA SERVICES ATTACHMENT (PA/AA)

Mail To:

E.D.S. FEDERAL CORPORATION
Prior Authorization Unit
Suite 88
6406 Bridge Road
Madison, WI 53784-0088

PA/AA

PRIOR AUTHORIZATION AODA SERVICES ATTACHMENT

1. Complete this form
2. Attach to PA/RF (Prior Authorization Request Form)
3. Mail to EDS

RECIPIENT INFORMATION

(1) LAST NAME	(2) FIRST NAME	(3) MIDDLE INITIAL	(4) MEDICAL ASSISTANCE ID NUMBER	(5) AGE
Recipient	IM	A	1234567890	29

PROVIDER INFORMATION

(6) PERFORMING PROVIDER'S NAME AND CREDENTIALS	(7) PERFORMING PROVIDER'S MEDICAL ASSISTANCE PROVIDER NUMBER	(8) PERFORMING PROVIDER'S TELEPHONE NUMBER
I.M. Performing, A.C.		(XXX) XXX. XXXX

(9) REFERRING/PRESCRIBING PROVIDER'S NAME	(10) REFERRING/PRESCRIBING PROVIDER'S MEDICAL ASSISTANCE NUMBER
I.M. Referring/Perscribing	87654321

PART A **TYPE OF TREATMENT REQUESTED:**

☒ **PRIMARY INTENSIVE OUTPATIENT TREATMENT**

- ☒ Individual ☒ Group ☒ Family
- Number of minutes per session: 60 Individual 180 Group 60 Family
- Sessions will be: ☐ Twice/month ☐ Once/week ☐ Once/month ☒ Other (specify) 5X/WK
- Requesting 16 hrs/week, for 4 weeks
- Anticipated beginning treatment date 01/03/91
- Estimated intensive treatment termination date 02/01/91
- Attach a copy of treatment design, which includes the following:
  (a) Schedule of treatment (day, time of day, length of session and service to be provided during that time)
  (b) Description of aftercare/follow-up component

Group 3 HR/day, 5 days/week
Ind. 2-1 HR sessions
Family 2-1 HR sessions

☐ **AFTERCARE/FOLLOWUP SERVICE**

- ☐ Individual ☐ Group ☐ Family
- Number of minutes per session: _____ Individual _____ Group _____ Family
- Sessions will be: ☐ Twice/month ☐ Once/week ☐ Once/month ☐ Other (specify)_____
- Requesting _____ hrs/week, for _____ weeks
- Estimated discharge date from this component of care _____

☐ AFFECTED FAMILY MEMBER/CO-DEPENDENCY TREATMENT

- ☐ Individual ☐ Group ☐ Family
- Number of minutes per session: _____ Individual _____ Group _____ Family
- Sessions will be: ☐ Twice/month ☐ Once/week ☐ Once/month ☐ Other (specify)_____
- Requesting _____ hrs/week, for _____ weeks
- Anticipated beginning treatment date _____
- Estimated affected family member/co-dependency treatment termination date _____
- Attach a copy of treatment design, which includes the following:
  (a) Schedule of treatment (day, time of day, length of session and service to be provided during that time)
  (b) Description of aftercare/follow-up component

PART B

1. Was the recipient in primary AODA treatment in the last 12 months? ☐ Yes ☒ No ☐ Unknown
   If "yes," provide dates, problem(s), outcome and provider of service:

2. Dates of diagnostic evaluation(s) or medical examination(s):

   12/15/90

3. Specify diagnostic procedures employed:

   12/21/90 - INTAKE ALCOHOLISM CHECKLIST & CLINICAL INTERVIEW.

303.91 ALCOHOL DEPENDENCE-CONTINUOUS AS MANIFESTED BY MALADAPTIVE PATTERN OF USE FOR 3 YEARS, BLACKOUTS, LOSS OF CONTROL, LEGAL AND FAMILY PROBLEMS ASSOCIATED WITH DRINKING.

296.2 MAJOR DEPRESSIVE DISORDER

5. Describe the recipient's current clinical problems and relevant history; include AODA history:

CLIENT HAS DECIDED TO RECEIVE TREATMENT AND COMMITTED HIMSELF TO ABSTINENCE FROM ALL MIND/MOOD ALTERING CHEMICALS. CLIENT HAS HAD A PATTERNED USE WHICH INCLUDED DRINKING 4-5X/WK CONSUMING 6-18 BEERS PER DRINKING BOUT. CLIENT REPORTS BEING INTOXICATED AT LEAST 1X WEEK. CLIENT BEGAN TRYING TO CONTROL HIS DRINKING ABOUT 2 YEARS AGO AFTER BEING ARRESTED FOR DRUNK DRIVING. SINCE THAT TIME HE HAS RECEIVED ONE OTHER DWI CONVICTION. CLIENT REPORTS GUILT AND SHAME ABOUT HIS BEHAVIOR. HE REPORTS PERIODS OF VIOLENCE WHILE INTOXICATED WHICH OCCURED IN HIS FAMILY. IN ADDITION, CLIENT REPORTS A POSITIVE GENETIC HISTORY FOR ALCOHOLISM, CLAIMING THAT HIS FATHER IS ALCOHOLIC.

6. Describe the recipient's family situation; describe how family issues are being addressed and if family members are involved in treatment. If family members are not involved in treatment, specify why not.

CLIENT LIVES WITH HIS FAMILY. HIS WIFE REPORTS SHE HAS BEEN CONCERNED ABOUT HIS DRINKING FOR 6 YEARS AND HAS ONLY RECENTLY REPORTED HER CONCERN TO HER SPOUSE. THE CHILDREN IN THE FAMILY CONSISTS OF A 13 Y/O SON AND A 10 Y/O DAUGHTER. THE 13 Y/O WAS VERY QUIET DURING THE FAMILY ASSESSMENT AND DENIED ANY CONCERN ABOUT HIS DAD'S DRINKING. THE DAUGHTER WAS ABLE TO EXPRESS HER WORRY AND ATTEMPTS TO DISCONTINUE HER DAD'S DRINKING. (i.e. HIDING HIS BEER). THE FAMILY AGREED TO ATTEND OUR EDUCATIONAL NIGHT AND ALSO AGREED TO PERIODIC FAMILY SESSIONS. THEY DECIDED AT THIS TIME NOT TO BE INVOLVED WITH MORE INTENSIVE TREATMENT.

7. Provide a detailed description of treatment objectives and goals:

1) CLIENT WILL LEARN BASIC INFORMATION ON ALCOHOLISM.
2) CLIENT WILL BE ABLE TO SHARE HIS DRINKING HISTORY TO GROUP BY THE 2ND WEEK.
3) CLIENT WILL VERBALIZE & IDENTIFY SELF AS ALCOHOLIC.
4) CLIENT WILL CONTINUE ABSTINENCE FROM ALCOHOL.
5) CLIENT WILL DEVELOP A SELF-HELP PROGRAM.
6) CLIENT WILL VERBALIZE IN HIS FAMILY HIS OWN HISTORY WITH ALCOHOL.
7) CLIENT WILL BEGIN TO IDENTIFY & EXPRESS FEELINGS.
8) CLIENT WILL OBTAIN A SPONSOR BY TERMINATION DATE.

8. Describe expected outcome of treatment (include use of self-help groups if appropriate):

CLIENT WILL CONTINUE TO DEVELOP AND MAINTAIN A SOBER LIFESTYLE. CLIENT WILL ALSO PARTICIPATE IN OUR 12 WEEK AFTERCARE PROGRAM. CLIENT WILL RETURN TO GAINFUL EMPLOYMENT.

Recipient Authorization

9. I have read the attached request for prior authorization of AODA services and agree that it will be sent to the Medicaid Program for review.

Signature of Recipient or Representative
(If representative, state relationship to recipient)

Relationship

Attach a photocopy of the physician's prescription for treatment. The prescription must be signed and dated within 3 months of receipt by EDS (initial request) or within 12 months of receipt by EDS (subsequent request). (Physician providers need not attach a prescription unless treatment is prescribed by another physician).

THE PROVISION OF SERVICES WHICH ARE GREATER THAN OR SIGNIFICANTLY DIFFERENT FROM THOSE AUTHORIZED MAY RESULT IN NON-PAYMENT OF THE BILLING CLAIM(S).

10. O. M. Performing
Signature of Performing Provider

Alcohol and Drug Counselor
Discipline of Performing Provider

I.M. SUPERVISING
Name of Supervising Provider

87654321
Provider Number of Supervising Provider

I. M. Supervising
Signature of Supervising Provider

MM/DD/YY
Date

PA04180L_JF/HB3